



THE UNIVERSITY *of* EDINBURGH

Edinburgh Research Explorer

Contrasting perceptions about the delivery of care in the community

Citation for published version:

Haycock-Stuart, E & Kean, S 2012, 'Contrasting perceptions about the delivery of care in the community', *Nursing Management*, vol. 18, no. 10, pp. 26-29. <https://doi.org/10.7748/nm2012.03.18.10.26.c8959>

Digital Object Identifier (DOI):

[10.7748/nm2012.03.18.10.26.c8959](https://doi.org/10.7748/nm2012.03.18.10.26.c8959)

Link:

[Link to publication record in Edinburgh Research Explorer](#)

Document Version:

Early version, also known as pre-print

Published In:

Nursing Management

Publisher Rights Statement:

© Haycock-Stuart, E., & Kean, S. (2012). Contrasting perceptions about the delivery of care in the community. *Nursing Management*, 18(10), 26-29. doi: 10.7748/nm2012.03.18.10.26.c8959

General rights

Copyright for the publications made accessible via the Edinburgh Research Explorer is retained by the author(s) and / or other copyright owners and it is a condition of accessing these publications that users recognise and abide by the legal requirements associated with these rights.

Take down policy

The University of Edinburgh has made every reasonable effort to ensure that Edinburgh Research Explorer content complies with UK legislation. If you believe that the public display of this file breaches copyright please contact openaccess@ed.ac.uk providing details, and we will remove access to the work immediately and investigate your claim.



Please refer to the published article for citation purposes.

Leading for quality care in the community: who counts?

Corresponding and Lead Author

Dr Elaine Haycock-Stuart, PhD, RHV, RM, RGN

Senior Lecturer

School of Health in Social Science

The University of Edinburgh

The Medical School, Teviot Place

Edinburgh. EH8 9AG

Scotland, UK

Daytime Telephone Number: 0044131 650 8442

FAX Number: 00 44 131 650 3891

e.a.haycock-stuart@ed.ac.uk

Dr Susanne Kean, PhD, MSc, RN, Dip Nursing Management & Education

Research Associate

School of Health in Social Science

The University of Edinburgh

The Medical School, Teviot Place

Edinburgh. EH8 9AG

Scotland, UK

Susanne.Kean@ed.ac.uk

Word Count 2250 excluding abstract

Please refer to the published article for citation purposes.

Leading for quality in the community: who counts?

Abstract

Background: Policy emphasises the role of leadership in meeting the healthcare quality agenda. As more care is delivered in the community setting it is important to evidence the quality of care patients and families receive from nurses working in the community.

Aim: To examine the impact of nursing leadership in the community setting on quality of care.

Method: A qualitative study involving individual interviews focus groups with nurse leaders, health visitors, district nurses, staff nurses and health care assistants working in the community (N=39).

Results: There is tension about the value of leadership between nurse 'leaders' (leading for care) and 'followers' (delivering for care). Nurse leaders indicate how they see the leadership role as critical seek to address quality issues through workforce planning and organisation.

Discussion: While senior nurse leaders argue that leadership impacts on quality of care in the community environment, frontline staff indicate that the skills of individual nurses is likely to be more pertinent to the quality of care in community nursing.

Conclusions: Addressing the policy drives for quality of care has been primarily a senior nursing leadership concern with little engagement between the frontline staff and senior nursing leaders.

Please refer to the published article for citation purposes.

Key words: Leadership, community nursing, quality, management

Introduction

Leadership and quality of care are key elements of current NHS policy driving the service and organisation of care in community nursing (Donaldson 2001, DoH 2009, Scottish Government (SG) 2007, 2008, 2009, 2010, Wong and Cummins 2007, Giordano 2010, Machell et al 2010). The work of nurses working in the community such as health visitors and district nurses has previously been described as 'invisible' (Hallett and Pateman 2000, Low & Hesketh 2002) and the current quality agenda is an opportunity for community nursing to make visible its contribution to the care of patients and families in the community setting. To identify how this is being played out in community nursing we undertook the following qualitative study.

The study

We collected data between April and December 2009 in three health boards in Scotland with an aim of examining 1) how leadership is perceived and experienced by community nurses and 2) to examine the interaction between recent policy and leadership development in community nursing. Data analysis identified quality of care as an important theme within our data.

Please refer to the published article for citation purposes.

The study involved 39 health visitors, district nurses, staff nurses, health care assistants and leaders from Agenda for Change (AfC) band 2 to 9 and Nurse Directors. Thirty one interviews and three focus groups were conducted within the community setting. Ethical approval was obtained prior to gathering data. Table 1 summarises the participants involved. The full study method is reported elsewhere (Haycock-Stuart 2010, Kean et al 2011). Qualitative data analysis was undertaken and the following reports findings about views of quality of care in community nursing and the role leadership has (or does not have) currently in meeting the quality agenda in the NHS.

Findings and Discussion

The community as a care environment

The context of care in community was considered by some senior nurse leaders to be poorly understood at the Boardroom level of NHS boards. As this senior nurse below explains there is a misconception that the 'real' nursing care is taking place in hospitals, whilst community nursing is concerned with reassuring chats and cups of tea!

And I think it's that bit about trying to explain to people that we have very sick folk in the community, that you live in a community, we have huge health challenges because there's a kind of feeling within health, I think, that all sick folk are sitting in the hospital and we're doing all the, you know, cups of tea and there, there stuff – and we're not at all, are we? I mean, we're doing real healthcare. (LN1.2)

Please refer to the published article for citation purposes.

The senior nurse went on to explain how a Board member expressed surprise to her that a person could be cared for at home in the community when experiencing two chronic illnesses and a leg ulcer! There is a lack of understanding about the complexity of work in the community setting resulting from the 'invisibility' of nursing work which for its contribution to the quality agenda to be recognised, nursing needs to address.

Who counts in community nursing?

Several senior nurse leaders considered nursing leadership to be pivotal and the driving force in respect of quality of care received in the community. However, frontline community nursing staff argued that leadership was far removed from care delivery and that it was they who were the 'backbone' driving the quality of care that patients and families received in the community. These contrasting views illustrate the mismatch in perceptions about the value of leadership between nurse 'leaders' (leading for care) and 'followers' (delivering for care) evident in our data.

Leadership in community nursing has a particular challenge in that the senior nurse leaders are often geographically situated quite remotely from the front line community nursing staff. There is evidence that this geographical distance lead to some extent to senior nursing leadership being perceive as distant and removed from the reality of frontline services delivering the patient care. However, distance was more complex than geography- since nurses at the frontline considered nurse leaders to be out of touch with the nursing issues relevant to patient care delivery and as such they were perceived by

Please refer to the published article for citation purposes.

frontline community nursing staff as having little, if any influence on quality of care in the community nursing setting.

The tensions in these different views are intensified as the data indicates that addressing the policy drives for quality of care has been primarily a senior nursing leadership concern with little engagement between the frontline staff and senior nursing leaders.

Quality: the driving force for service organization and delivery?

A few nurse leaders indicated that they sought out good practice to drive, motivate and develop other nurses in the community to improve quality of care. Arguably, this approach to leadership helps staff feel engaged, valued and empowered in the quality of their care. However, the lack of organisational infrastructure to identify, monitor and share good practice hinders the recording and reporting quality of care in practice which can transcend the nursing hierarchy and be available for health board scrutiny-which would be one step nearer to making the invisible-visible. Change in practice was rarely well substantiated on the basis of quality.

The service and organisation mechanisms to direct, capture and monitor quality of care in community nursing have not yet been established in community nursing. Paradoxically, the most reported mechanisms to capture quality were the exact opposite of what the organisations wish to achieve-complaints! As this senior nurse explains, complaint mechanisms indicate the quality of care and most of these complaints in community

Please refer to the published article for citation purposes.

nursing are to do with nurses 'being nice or not nice' –the relationship aspects, not the more technical aspects of care.

I mean, a lot of the patient care and quality, we'll also get through complaints, which is mostly around someone not being nice to me, certainly the nursing ones tend not to be about technical issues, they tend to be more about being nice or not nice.

(Senior Nurse 2.1)

Perhaps it is no surprise that the relationship aspects are important to patients? Calman (2006) indicated how patients in acute services consider that the nursing profession concerns itself with quality of the more technical aspects of care through professional regulation and that patients concern themselves more with the relational aspects. Notably however, the more technical competence aspects of nursing care were not systematically monitored to capture evidence of quality care in community nursing.

Organisational decision making and skill-mix for quality care

The lack of indicators and evidence illustrating the value of different nurses contribution to care of people in the community meant it was hard for nursing managers to identify the right people are delivering different aspects of nursing care when planning the organization of the workforce for the delivery of quality care. As this nurse director explains:

Please refer to the published article for citation purposes.

'We've really tried to make sure that we've married our workforce workload planning work with the patient and quality of care at the heart, not money and the profession. All in a kind of triad, rather than saying, "we need more nurses but I'm not going to give you anything in return". We need nurses, well in turn we're going to improve the quality of care'. (Nurse Director 1.1)

The point being made is that different AfC bands of staff have a different cost associated with them and this cost needs to balance with the quality of the service. The higher grade staff is more expensive to employ for nursing roles than a lower grade of staff and evidence is needed that the higher grade of staff is worth the extra cost by resulting in better quality of care. Yet, in this study we identified limited indicators for quality care in community nursing which could assist the organisational decision making of people in leadership roles. As such, it is difficult to see how skill-mix is organised to assure quality of care or justify resources for different skill-grades on the basis of quality as opposed to purely financial terms.

To illustrate this we can consider nursery nurses and health visitor roles with families with pre-school children. Within our data we had evidence of nursery nurses routinely visiting 'core' families with no initial additional health needs identified, some nursery nurses worked primarily as lone workers with distant supervision by health visitors.

Please refer to the published article for citation purposes.

So, when babies are first born, we go in to see their mums and the families for up to 8 weeks and then they're signed off by the health visitor.

Nursery nurses with expertise in child development and child play can support parenting and childcare work with families. However, the expertise of nursery nurses is not in maternal health, raising questions about how well maternal health can be assessed when nursery nurses are undertaking much of the work with core families?

In contrast to nursery nurses, the ongoing assessment by the health visitors and their ability to identify changing maternal health as well as unfolding health issues for other family members meant they provided a much more comprehensive ongoing assessment and help to core families. As this health visitor explains:

They then have a child and a whole load of problems erupt. [] ...you can then see her going downhill, you can see relationship problems occurring, you can see problems occurring with the attachment to the child. (HV3.1)

The education and experience of different frontline staff is considered to impact on the quality of care in community nursing, but the lack of meaningful indicators of quality of care means this is an unaddressed issue. The illustration of the nursery nurse and health visitor indicates where different expertise lies- for nursery nurses it is within child development and child play but not maternal health. Nursery nurses do have a role to play in those families that do need support in areas of child development and child play, yet

Please refer to the published article for citation purposes.

ironically, these are more likely to be families with additional or intensive needs rather than core families.

District nursing also illustrates variability in the quality of the community nursing service as acknowledged by this district nurse.

We'd have – not every time but we'd have a debriefing when somebody died to look at that and that was a big part of the focus for that district nursing sister but other folk felt, well OK, that's fine for patients with – cancer patients who're dying but actually there's a big other – a lot of our caseload that isn't getting that same quality of care. (DN2.2)

The patients treated at home for cancer and treated palliatively are perceived by nurses to receive a better quality of care than patients with other illness trajectories. However, the community nurses were unaware of any metrics or indicators that might evidence this perceived variability in the quality of the community nursing services. The community nurses argues that they thought the clinical pathway helped to ensure better quality of care compared to other services with no such pathways to guide the organisation of care.

Conclusions

Currently the link between leadership and high quality care in community nursing is not well evidenced. Senior nurse leaders are leading the quality agenda, however the limited engagement between them and frontline community nurses contributes to tensions about

Please refer to the published article for citation purposes.

how to achieve high quality care. Wong and Cummins (2007) indicate that leadership can influence some aspects of quality in the acute setting, so it is highly likely that leadership in community nursing does matter. Making the 'invisible' (Hallett and Pateman 2000, Low & Hesketh 2002) visible is a key challenge for community nursing. Developing quality indicators to demonstrate the value of leadership as well as the quality of work of frontline staff is now essential for the quality of community nursing care to be appreciated.

References

- Calman, L., 2006. Patients' views of nurses' competence. *Nurse Education Today* 26 719-725.
- Department of Health., 2002. *Shifting the Balance of Power: the next steps*. Department of Health, London.
- Department of Health., 2009. *High Quality Care for All*. Department of Health, London.
- Donaldson, L., 2001. *Safe high quality health care: Investing in tomorrow's leaders*. Quality in Health Care 10, 8-12.
- Giordano, R., 2010. *Leadership needs of medical directors and clinical directors*. The King's Fund, London.
- Hallett, C. E., Pateman, B. D., 2000. The 'invisible assessment': the role of the staff nurse in the community setting. *Journal of Clinical Nursing* 9, 751-762.
- Haycock-Stuart, E. A., Kean, S., Baggaley, S., Carson, M., 2010. Understanding leadership in community nursing in Scotland. *Community Practitioner* 83 (7), 24-28.

Please refer to the published article for citation purposes.

Kean, S., Haycock-Stuart, E. A., Baggaley, S., Carson, M., (2011) Followers and the co-construction of leadership. *Journal of Nursing Management*. 19, 507-516.

Low, H., Hesketh, J., 2002. *District Nursing: the invisible workforce*. Queens Nursing Institute, London.

Machell, S., Gough, P. Naylor, D., Nath, V., Steward, K., Williams, S., 2010. *Putting quality first in the boardroom: improving the business of caring*. The King's Fund, London.

Scottish Government., 2007. *Better Health, Better Care: action plan*. Scottish Government, Edinburgh Access at:

<http://www.scotland.gov.uk/Publications/2007/12/11103453/0>

Scottish Government., 2008. *Leading Better care*. Scottish Government, Edinburgh.

Scottish Government., 2009. *Delivering quality through leadership*. Scottish Government, Edinburgh

Scottish Government., 2010. *The healthcare quality strategy for NHS Scotland*. Scottish Government, Edinburgh.

Wong, C., Cummings, G., 2007. The relationship between nursing leadership and patient outcomes: a systematic review. *Journal of Nursing Management* 15 (5), 508 – 521.

Acknowledgements

We wish to thank the Queens Nursing Institute Scotland for their financial support, Sarah Baggaley (SB) and Maggie Carson (MC) for their work on the project and the steering

Please refer to the published article for citation purposes.

group members for their guidance during the study. We wish to dedicate this paper to the memory of Susan McMeel.

Table 1: Sample of participants

District Nurse	8
Community Staff Nurse	12
Health Visitor	3
School Nurse	0
Nursery Nurse	2
Health Care Assistant	2
Team Leader (TL) (3=DN, 2=HV)	5
Lead Nurse (LN)	3
Acute Care Managers for Community Sector	1
Assistant Nursing Director	1
Director of Nursing	2

Box 1 The NHSScotland quality strategy quality themes (SG 2010)

A specific focus on quality that ensures:

- Caring and compassionate staff and services;

Please refer to the published article for citation purposes.

- Clear communication and explanation about conditions and treatment;
- Effective collaboration between clinicians, patients and others;
- A clean and safe care environment;
- Continuity of care; and
- Clinical excellence.

Box 2 Change is needed to meet the quality agenda (SG2010).

Change to develop and achieve:

- Leadership at all levels;
- Shared ownership - winning hearts and minds;
- Partnership with staff, involvement of patients and carers;
- Embedding quality in day-to-day work;
- Creating the right infrastructure - people, information technology;
- Energy and commitment - tying it all together;
- Focus on the right outcomes and targets;
- Meaningful measures, evidence and analysis

Box 4. Explanation of the terms used in health visiting to acknowledge the level of identified health needs in families.

- **Core families** – parents and children with no additional health or social needs other

Please refer to the published article for citation purposes.

than the need for the set health promotion programme including child health surveillance, parenting education and immunisation. Parents will make contact if they identify a health need in their child.

- **Additional families** – have children or parents with health or social needs requiring health intervention.
- **Intensive families** – have children or parents requiring intensive input from more than one agency e.g. social services.

Please refer to the published article for citation purposes.

Box 3 Sample of interview schedule and focus group questions focusing on quality

Examples of interview & focus group questions:

- Can you tell me how leadership is organised in your area?
- What actually happens when people lead?
- What is shaping the leadership in your organisation/ health board?
 - Policy agenda
 - Health board agenda
 - Personal agenda
- Does leadership have any impact on quality of care?
 - If so – how?
- How do you monitor the impact of leadership on quality of care?
- What is the impact of the leadership policy agenda on leadership in practice?
- What is the patient's role in all of this?
- Are patients consulted for feedback of care quality or when changes are planned?
- How do you ensure patient voices are heard?
- What challenges do you see in the future for leadership in community care?
- What is it that you are trying to achieve in community nursing?
- What, in your view, is being achieved in community nursing?
 - Does this differ from the past?
 - If so – how?
- What, in your view, is leadership achieving in community nursing?
-

Questions for individual interviews and focus groups changed over time in accordance with emerging insights.